Semi-Annual Report to the

Joint Legislative Oversight Committee

on Health and Human Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2011-12: Spring Report

Session Law 2006-142, Section 2.(a)(c)

as Amended by Session Law 2011-291, Section 2.42.(c)

April 1, 2012

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

The General Statute continues to require the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) to report to the Joint Legislative Oversight Committee on Health and Human Services every six months on progress made in seven statewide performance domains. This semi-annual report builds on the measures in the previous reports.

Domain 1: Access to Services – The system measures the number of individuals actually receiving services against the number of individuals projected to have a mental illness, developmental disability or substance use disorder based upon national prevalence rates. Among all the age-disability groups, a greater percentage of children estimated to have a mental illness are receiving services. Just over half of children (56%) and adults (52%) estimated to have a mental illness are provided services by the public system. Only 21% of children and 40% of adults estimated to have developmental disabilities are provided services by the public system. The amount of services provided to persons estimated to have substance abuse problems (10% of adolescents and 12% of adults estimated to be in need) continues to be an area of significant concern. Over the past two calendar years, the timeliness of initial services for routine care has fluctuated and reached a high of 82% and most recently a low of 69%.

Domain 2: Individualized Planning and Supports – Consumers with mental health and substance abuse disorders (regardless of age group) overwhelmingly report having a choice in their provider. The majority of consumers with developmental disabilities report having some input in how they spend their day, money and free time (very similar to consumers in all participating states). In addition, the majority of consumers with developmental disabilities report their Case Managers are responsive to their needs. For mental health and substance abuse consumers, the large majority of children and adolescents report family involvement in service planning and treatment, with adolescent substance abuse consumers reporting the lowest level of family involvement.

Domain 3: Promotion of Best Practices – For mental health and substance abuse consumers, the last several quarters have shown significant increases in the use of a wider array of best practice services for both child and adult consumers. A greater number of persons discharged from the state alcohol and drug treatment centers are being seen within seven days of their discharge.

Domain 4: Consumer-Friendly Outcomes – North Carolina consumers with developmental disabilities report strong participation in community life such as shopping, entertainment, going out to eat, running errands, and exercise/sports (very similar to reports from consumers in all other states). Parents and guardians of child mental health consumers (ages 6-11) were more likely to report services were very helpful in three key quality of life indicators than were adolescent mental health consumers (ages 12-17). Compared to adult mental health consumers, adult substance abuse consumers were slightly more likely to report that services were very helpful to them in improving their education, housing, and employment.

Domain 5: Quality Management Systems – (1) The Department is in the process of expanding the 1915 (b)/(c) Medicaid Waiver. As a part of this expansion process, the Department has established several committees to provide guidance, technical support, and monitoring for the Local Management Entities as they become Managed Care Organizations. (2) In an effort to monitor and ensure a timely response to consumer adverse events, the Division has established the Health and Safety Committee. This committee meets monthly to review patterns and trends in complaints and consumer incidents, provide guidance to Local Management Entities on response to individual complaints and incidents as needed, identify emerging issues, and implement approved action plans. Progress, results, and recommendations for action are reported to the Quality Steering Committee.

Domain 6: System Efficiency and Effectiveness – The timely and accurate submission of data to the Division has improved over the past eight quarters, increasing from 84% to 89%. The submission of reports to the Division has remained consistently high, fluctuating between 91% and 100% over the past eight quarters.

Domain 7: Prevention and Early Intervention – (1) In North Carolina, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) set-aside funds are used to support strategies (programs, practices and policies) implemented across all counties and allocated to community providers based on a plan consistent with local needs. Comparing state fiscal year 2011 to 2010, there was an increase in 2011 in the number of youth reached in evidence based curricula prevention programs and strategies in the selective and indicated target population. (2) The State's current substance abuse prevention infrastructure is being strengthened by a one year capacity building grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). A Policy Consortium has been developed consisting of public and private stakeholders to garner support for identifying substance abuse problems in local communities and developing a plan with recommendations to address them.

Table of Contents

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2011-12: Spring Report

Introduction

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to Session Law 2006-142, Section 2.(a)(c). This legislation was amended by Session Law 2011-291, Section 2.42 (c) which requires this semi-annual report on progress made in seven statewide performance domains to be submitted to the Joint Legislative Oversight Committee on Health and Human Services. This semi-annual report builds on the measures reported in previous reports (See Appendix A).

Domain 1: Access to Services

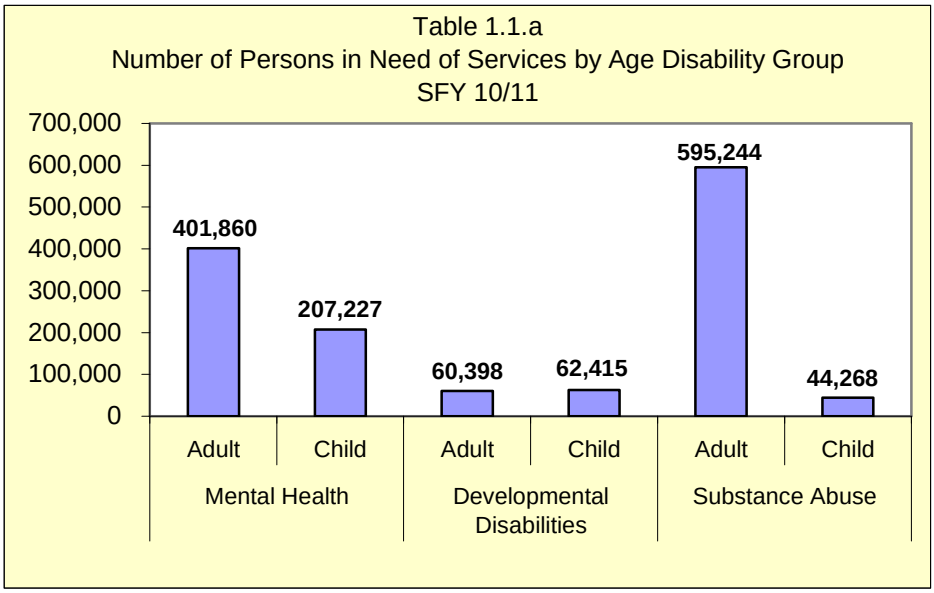
Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse service needs who request help. It is a nationally recognized measure of service performance.

Measure 1.1: Persons Receiving Community Services

National research estimates the occurrence of chronic and serious mental health, developmental disabilities and substance abuse problems in the population (*prevalence*). (See Appendix B for sources.) Applying the most recent estimates to North Carolina's populations translates into 401,860 NC adults needing mental health (MH) services and a little more than 595,000 needing substance abuse (SA) services each year. Slightly more than 60,000 adults need services and supports for a developmental disability (DD). [1]

In terms of children and adolescents, just over 207,000 children experience severe and emotional disorders each year that, if not addressed, can lead to a MH disorder (assuming the 12% prevalence rate for older youth, ages 9-17, also applies to children under age 9). Almost 62,500 children and adolescents (ages 0-17) in North Carolina have a developmental disability and another 44,268 adolescents (ages 12-17) experience a diagnosable SA disorder. (See Table 1.1.a on the next page.)

[1] The numbers presented here include all persons in North Carolina estimated to need mh/dd/sa services, including those who may be served by private agencies or other public systems.

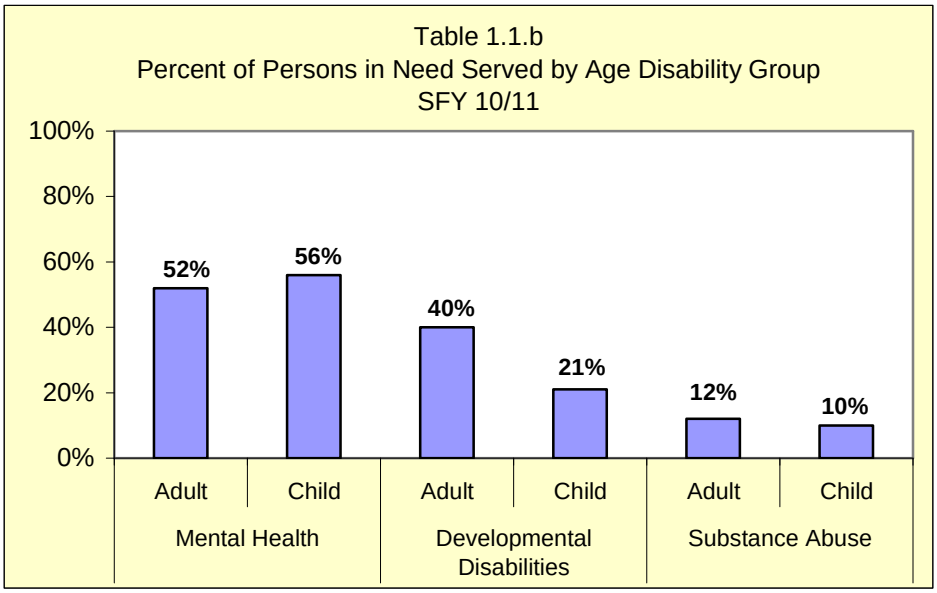


SOURCE: Office of State Budget and Management (OSBM) State Demographics Unit, July 2011 population projection data.

The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings. Tracking the number of persons in need who receive community-based services (*treated prevalence*) through the public MH/DD/SAS system provides a barometer of progress on that goal.

Table 1.1.b, on the next page, presents the percent of persons estimated to be in need who received publicly-funded community-based services during the last state fiscal year.[2] This percentage provides information that the Division uses to establish reasonable targets and to evaluate the need for future changes to fiscal or programmatic policies.

[2] The number of persons in need of services (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA).



SOURCE: Medicaid and State Service Claims Data. July 1, 2010 - June 30, 2011.

As seen in Table 1.1.b., the state's public system serves only twelve percent of adults estimated to have substance abuse disorders compared to 52% of adults estimated to have mental health disorders and 40% of adults with developmental disabilities. This is, in part, a reflection of the larger percentage of individuals with mental health disorders and developmental disabilities who are Medicaid-eligible compared to the percentage of Medicaid-eligible individuals with substance abuse disorders.

The state serves 56% of children and adolescents (ages 3-17) estimated to need mental health (MH) services and 21% of children and adolescents (ages 3-17) estimated as needing developmental disabilities (DD) services. Ten percent of adolescents (ages 12-17) projected to be in need of substance abuse (SA) services receive them through the state's MH/DD/SA service system.

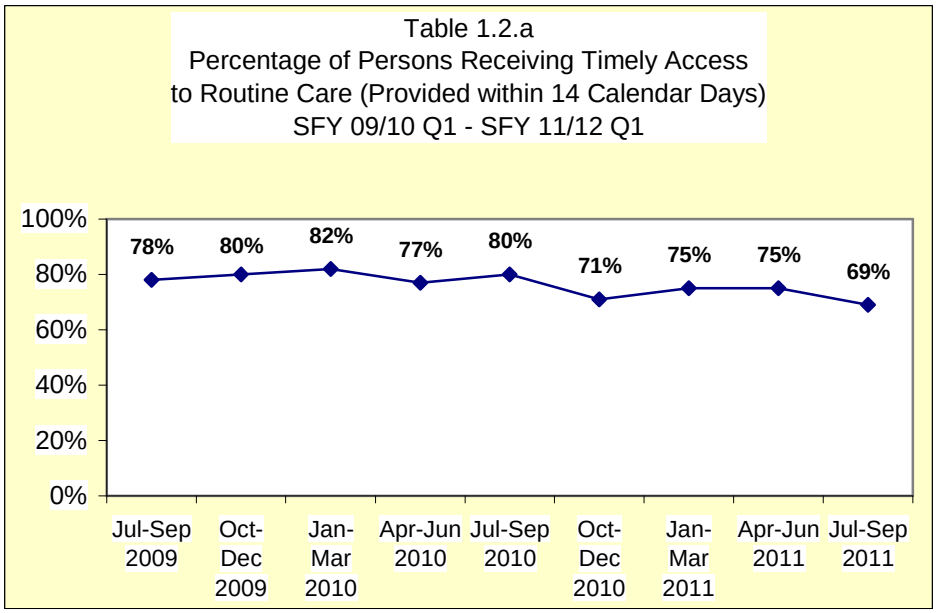
Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[3] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that results in more trauma to the individual and results in more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

Table 1.2.a, on the next page, shows fluctuation in the percentage of consumers who seek routine (non-urgent) care and are actually seen by a provider within fourteen days of requesting services (the third quarter of calendar year 2011 had a low of 69% whereas the beginning of that same calendar year had a high of 75%). In the last quarter of calendar year 2011 the percent of those

[3] Health Plan Employer Data and Information Set (HEDIS©) measures.

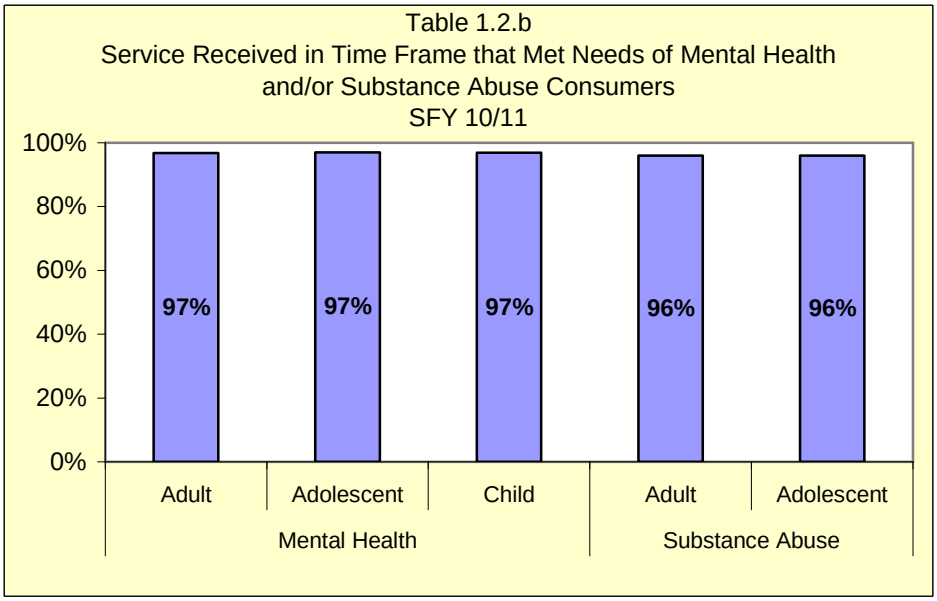
who are seen within two hours in emergency situations and within 48 hours in urgent situations is even higher, at 100% and 81% respectively (not shown).



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS as part of DHHS-LME Performance Contract.

The Division continues to work with LMEs to improve consumers receiving their first services in a timely fashion.

As shown in Table 1.2.b below, almost all mental health and substance abuse consumers or parents of child consumers (regardless of age group) reporting data during their initial assessment in SFY 2010-11 stated that services were received in a time frame that met their needs.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2010 - June 30, 2011.

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to the individual – and their family, where appropriate – are more likely to engage them in service and encourage them to take charge of their lives. Services that address what is important for them produce good life outcomes more efficiently and effectively.

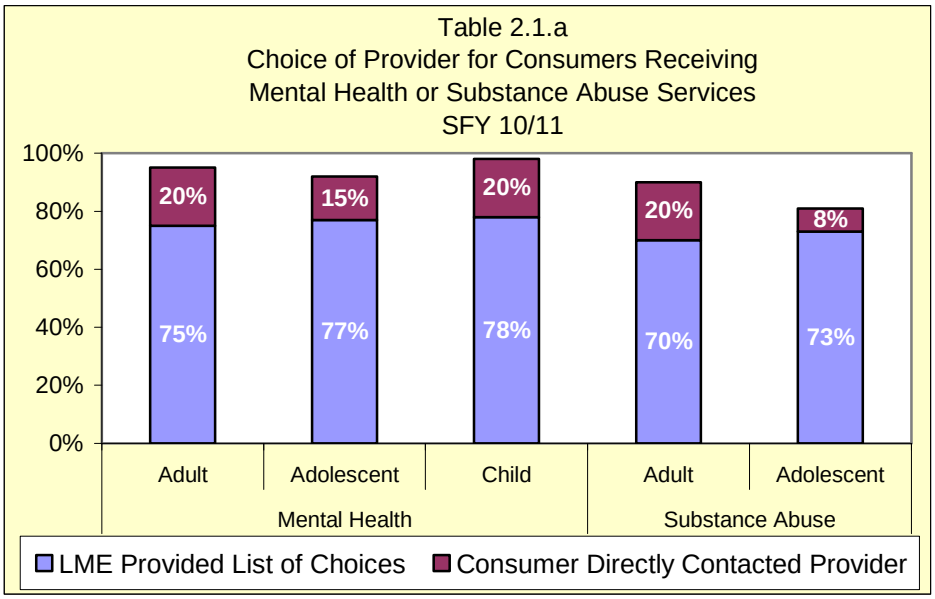
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice

Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help.

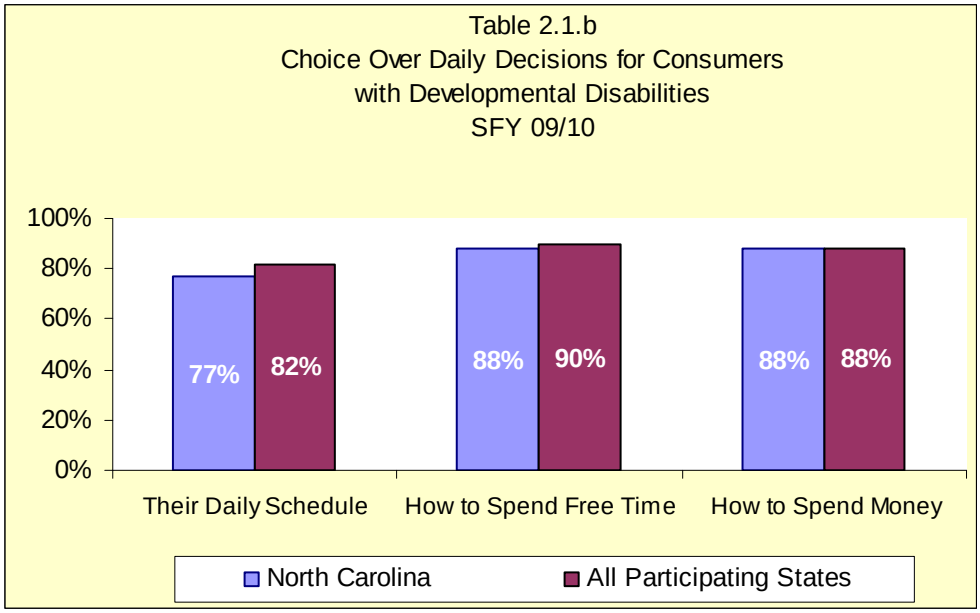
Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.a): About three-fourths of mental health consumers (regardless of the age group) and seven out of ten adult and adolescent substance abuse consumers reporting outcomes data in SFY 2010-11 said that the LME gave them a list of providers from which to choose services (see Table 2.1.a). (See Appendix B for information on NC-TOPPS). Most of the remaining consumers reported they contacted the provider directly and a very small percentage of consumers reported they did not receive a list of options. The exception was adolescent substance abuse consumers in which 19% reporting they did not receive a list of options.

Table 2.1.a
Choice of Provider for Consumers Receiving
Mental Health or Substance Abuse Services
SFY 10/11



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2010 - June 30, 2011.

Consumers with Developmental Disabilities (Table 2.1.b): In annual interviews with DD consumers, the majority of consumers reported choosing or having some input in how they spend their day (77%), free time (88%), and money (88%). Overall, there was very little difference between North Carolina consumers and consumers from all states participating in the project. (See Appendix B for more information on this survey.)

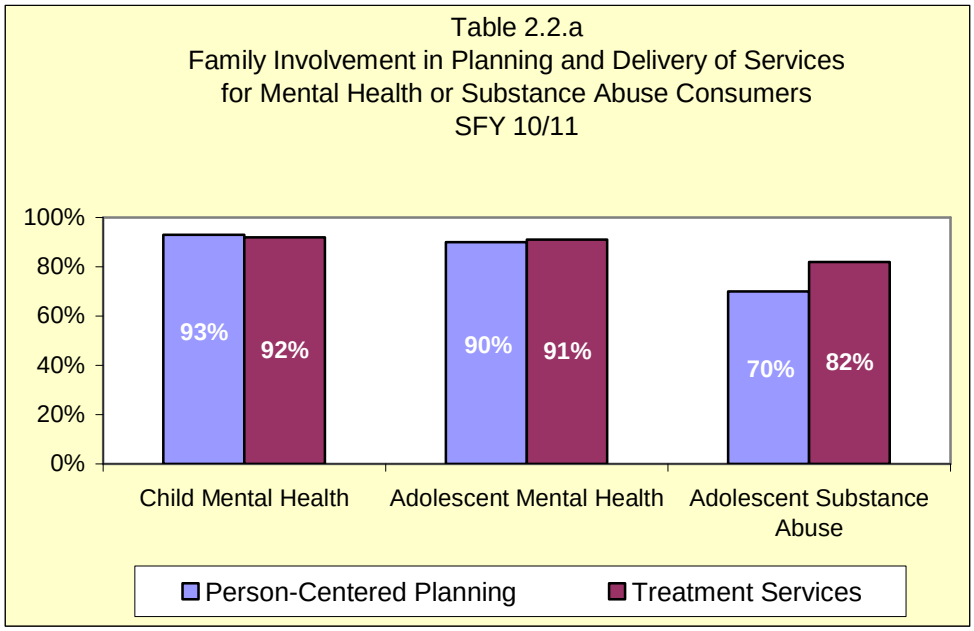


SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2009-10, North Carolina (NC) compared to All Participating States (All).

Measure 2.2: Person-Centered Planning

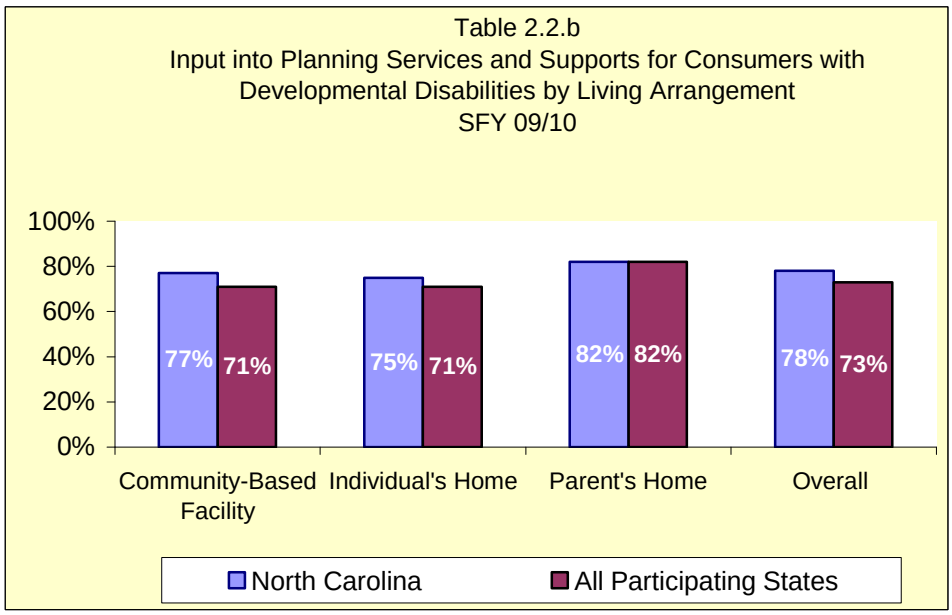
As the following tables show, the majority of consumers are involved in the service planning and delivery process.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.a): Table 2.2.a, presented on the next page, shows that the overwhelming majority of families of children and adolescents with mental health disorders (nine out of every ten families) are involved in service planning and delivery. For families of adolescents with substance abuse disorders, approximately seven out of ten are involved with service planning and 82% are involved with service delivery.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2010 - June 30, 2011

Consumers with Developmental Disabilities (Table 2.2.b): In SFY 2009-10, approximately three-fourths (78%) of North Carolina consumers with developmental disabilities reported that their case manager is responsive to them regarding services and supports needed (see Table 2.2.b below). North Carolina consumers who live in community based facilities or in their own home were more likely to report involvement in service coordination compared to consumers in all states using this survey. Consumers in North Carolina who live in their parent's home were equally as likely as those in all other states to report involvement in service planning. (See Appendix B for more information on this survey.)



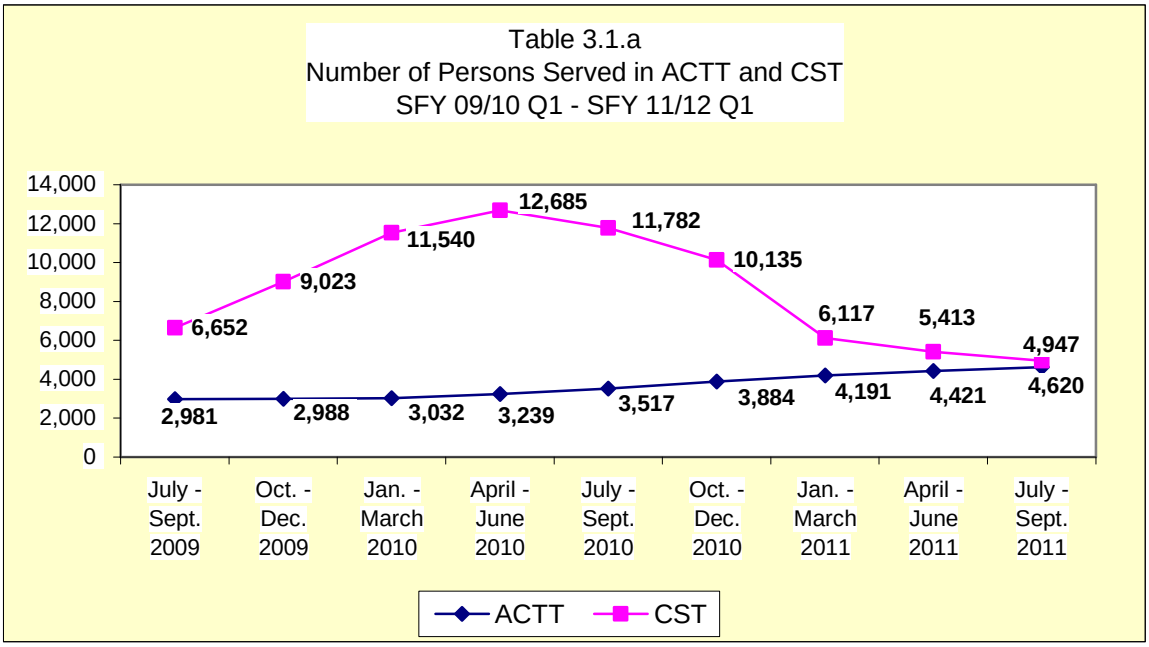
SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2009-10, North Carolina (NC) compared to All Participating States (All).

Domain 3: Promotion of Best Practice

Measure 3.1: Persons Receiving Evidence-Based Practices

Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a, the number of adults served in CST increased during SFY 2009-10 and then declined to its lowest level by the beginning of SFY2011-12. This decrease was expected as the Division has worked to restructure services so that consumers who had the greatest need would be able to receive the appropriate level of services through Critical Access Behavioral Health Agencies (CABHAs) which provide a continuum of care for a specified age disability group. Persons receiving these services are either stepped up to more intensive services or stepped down into less intensive services during their continuum of care. Conversely, ACTT has increased 55% during the past two state fiscal years.

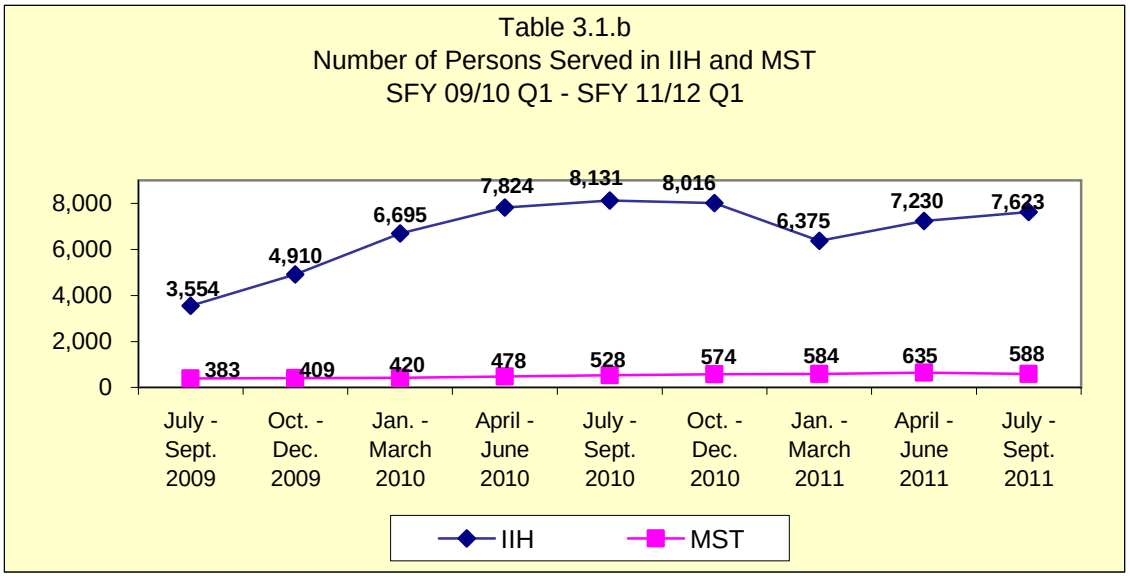
Table 3.1.a
Number of Persons Served in ACTT and CST
SFY 09/10 Q1 - SFY 11/12 Q1



SOURCE: Medicaid and State Service Claims Data. July 1, 2009 – December 31, 2011.

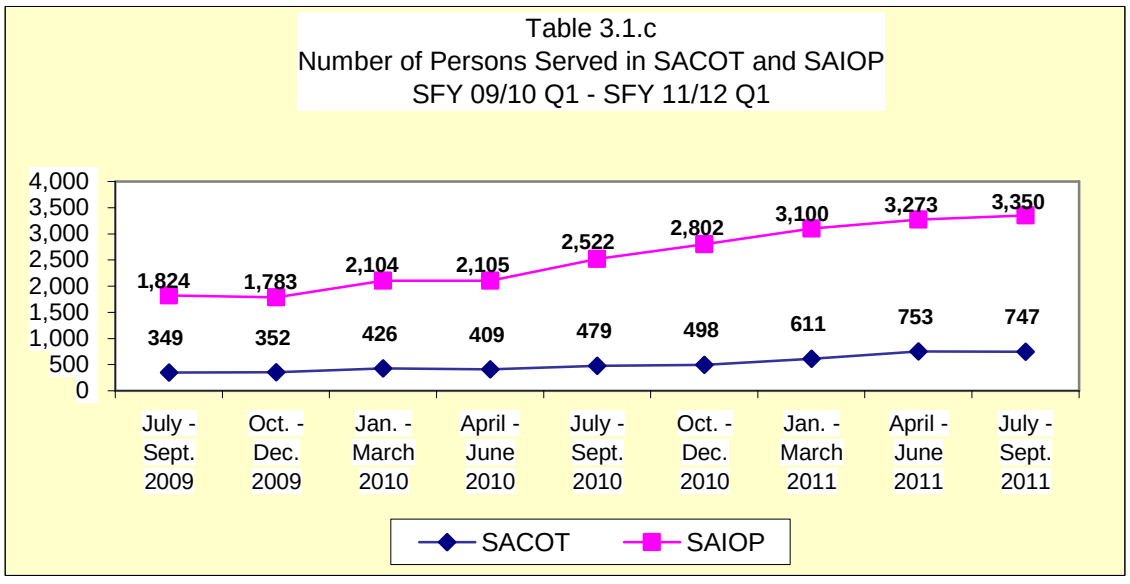
Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children placed in residential and inpatient care. Table 3.1.b. on the next page, shows that the number of youth served in IIH increased 129% from the beginning of SFY 2009-10 until the first quarter of SFY 2010-2011 when this number began to decline and level off at the end of SFY 2010-2011. Similar to CST, this decrease was expected as the Division has worked to restructure services so that consumers who had the greatest need would be able to receive the appropriate level of services through CABHAs which provide a continuum of care for a specified age disability group. Therefore, consumers receiving IIH received this

service and were either transitioned to more intense or less intense services during their continuum of care. Conversely, MST increased 54% during the past two fiscal years.



SOURCE: Medicaid and State Service Claims Data. July 1, 2009 – December 31, 2011.

<u>Consumers with Substance Abuse Disabilities</u>: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. SAIOP has seen an 84% increase in the number of persons served since the beginning of SFY 2009-10 (see Table 3.1.c). SACOT services have slowly increased in the last two years serving a low of 349 consumers in the first quarter of SFY 2009-10 to a high of 747 consumers in the first quarter of SFY 2011-12.



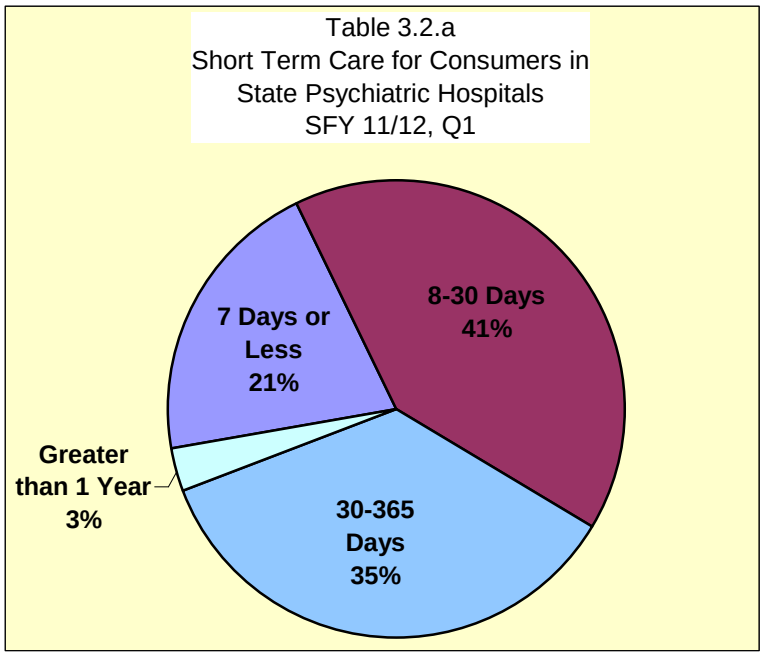
SOURCE: Medicaid and State Service Claims Data. July 1, 2009 – December 31, 2011.

Measure 3.2: Management of State Facility Usage

Community Crisis Care and Short-Term Use of State Hospitals: A service system in which individuals receive the services and supports they need in their home communities allows them to stay connected to their loved ones. This is a particularly critical component of recovery or self-determination in times of crisis. As discussed under Measure 3.1, service systems that provide community-based crisis response inpatient services can help individuals maintain support from their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

As stated in previous reports, North Carolina has used its state psychiatric hospitals to provide both acute (30 days or less) and long-term care. In most other states, acute care is provided in community hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay.

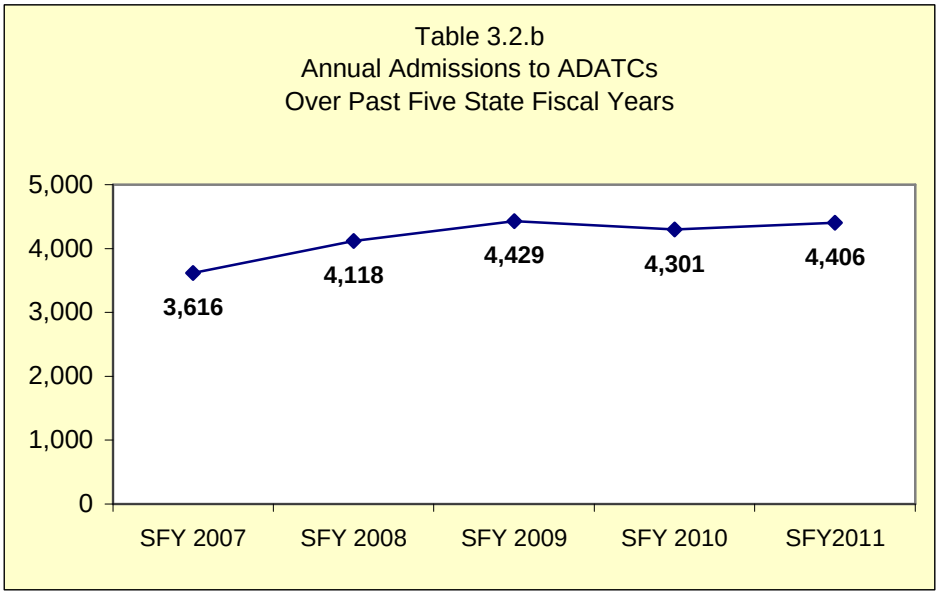
Table 3.2.a shows that just over six in ten (62%) of discharges during the first quarter of SFY 2011-12 were for consumers with lengths of stay for 30 days or less. Of the 713 discharges, 21% (n=146) were for consumers who discharged within seven days of admission, a drop of eleven percentage points from the first quarter of the previous fiscal year. Additionally, stays of 8-30 days decreased by three percentage points and stays of 30 days to one year increased by twelve percent during the same time period.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)
Data for discharges during July 1 - September 30, 2011; N=713 discharges.

Acute Care in State Alcohol and Drug Treatment Centers: In contrast to efforts to *reduce* the use of state psychiatric hospitals for short-term care, the Division continues to work with the Division of State Operated Facilities (DSOHF) to *increase* the use of state Alcohol and Drug

Abuse Treatment Centers (ADATCs) for acute inpatient care for individuals with substance use disorders. ADATCs are critical resources, providing services to individuals with co-occurring substance abuse and mental health disorders that require 24-hour inpatient hospitalization. Due to an increase in acute capacity in the ADATCs and enhanced management practices, total admissions to ADATCs has climbed substantially from 3,616 in SFY 2006-07 to 4,406 in SFY 2010-11 (a 22% increase). (See Table 3.2.b)



SOURCE: DMH/DD/SAS Consumer Data Warehouse (CDW), Annual Statistical Reports for Alcohol and Drug Abuse Treatment Centers. Admissions from SFY 2007 through SFY 2011.

Measure 3.3: Transitions to Community from State Developmental Centers

The Division of State-Operated Healthcare Facilities and the Division are working together to increase opportunities for individuals with developmental disabilities to live in community settings, when appropriate and desired. For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.[4] This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. During calendar year 2011, a total of five individuals were discharged from the general population of the developmental centers to the community.[5] Table 3.3.a on the next page, shows the type of community setting to which the individuals moved.

[4] Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

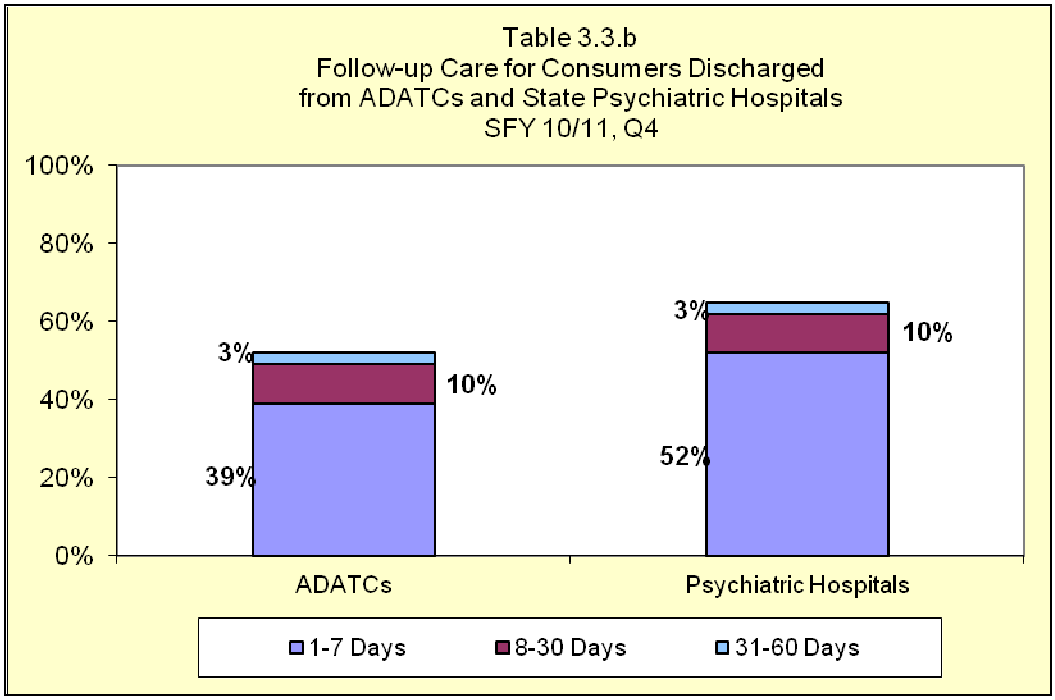
[5] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

Table 3.3.a
Follow-Up Care for Consumers with Developmental Disabilities (DD) Discharged from the General Population of the State Developmental Centers
Calendar Year 2011

Time Period	Number of Individuals Moved to Community	Type of Community Setting
January – March 2011	1	1 to ICF-MR group home
April – June 2011	1	1 to supervised living home
July – September 2011	3	1 to ICF-MR group home 2 to family home
October – December 2011	0	N/A

Data above includes three developmental centers; J. Iverson Riddle Center, Murdoch Center, and Caswell Center.

Over the past few years the Division has worked closely with LMEs to improve care coordination and follow-up services. Because of the emphasis on improving the timeliness of follow-up care for persons discharged from state psychiatric facilities and ADATCs, the state has seen notable increases in consumers receiving care in the community following discharge. As shown in Table 3.3.b, on the next page, more than half (52% out of 851) of persons discharged from state ADATCs are seen for follow-up care, with two-fifths (39%) receiving care within seven days of discharge. One year ago, slightly less than one-third of consumers discharged from an ADATC were seen within seven days. Follow-up care for the state psychiatric hospitals is somewhat better. Almost two-thirds (65% out of 848) of persons discharged from state psychiatric hospitals receive follow-up care, a little more than half (52%) of those discharged were seen within seven days. One year ago, the same percentage (52%) of consumers discharged from a state psychiatric hospital were seen within seven days. The Division will continue to emphasize this critical continuity of care issue with the expectation that more consumers will be seen in a timely manner.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges April 1 - June 30, 2011); Medicaid and State Service Claims Data (for claims paid through October 31, 2011)

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system improvement is building a recovery-oriented service system. Recovery and stability for a person with disabilities means having independence and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

All persons – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. SAMHSA and CMS support the use of a wide variety of measures of consumers' perceptions of service outcomes and measures of functioning in areas such as:

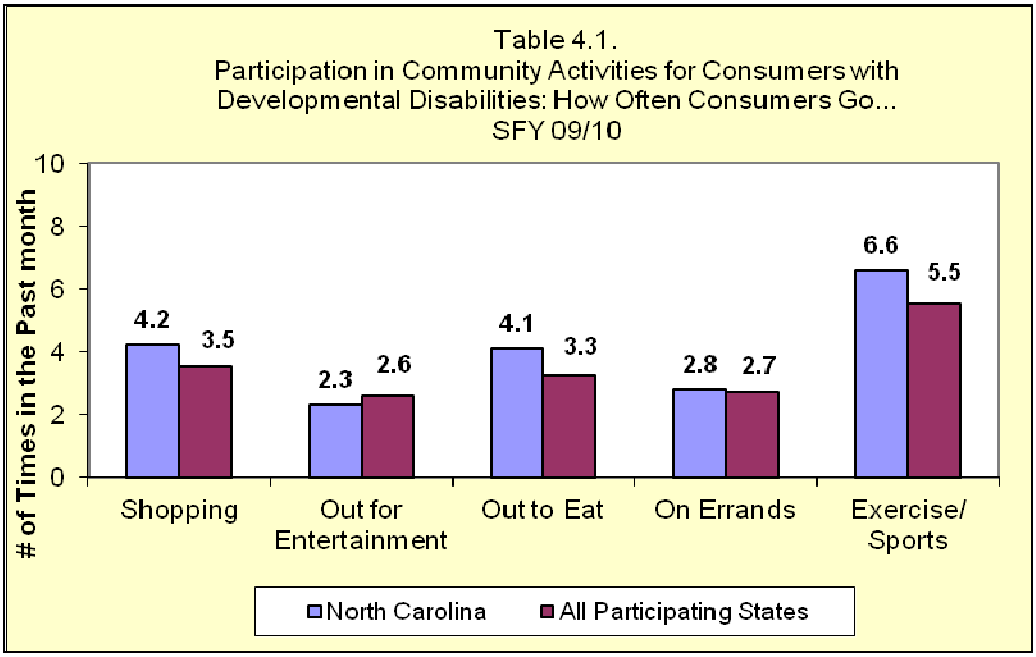
- symptom reduction, abstinence, and/or behavioral improvements,
- housing stability and independence,
- enhanced employment and education,
- social connectedness,
- reduction in emergency department and hospital inpatient care,
- reduction in criminal involvement, and
- participation in self-help and recovery groups.

Based on analysis of data on consumer outcomes, the Division adopted improvements in two of these areas – housing and employment / education – as objectives in the *State Strategic Plan*

2007-2010. Results of initiatives in these areas can be found in the *Spotlights on Progress Reports* at http://www.ncdhhs.gov/mhddsas/stateplans/plans_accomplishments/index.htm #spotlight. Current DHHS strategic planning continues emphasis on these issues for SFY 2011-2012.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

In annual interviews with consumers with developmental disabilities in SFY 2009-10, the overwhelming majority of North Carolina consumers reported participation in community life (see Table 4.1 below). In SFY 2009-10, the Consumer Survey assessed how often individuals participated in everyday activities in their communities, such as shopping, entertainment, going out to eat, running errands, and exercise/playing sports. North Carolina consumers participated in shopping, eating out, and exercising more often in a month than consumers among all participating states. North Carolina consumers did not differ significantly from consumers among all states using the survey in the areas of going out for entertainment and running errands. (See Appendix B for details on this survey.)

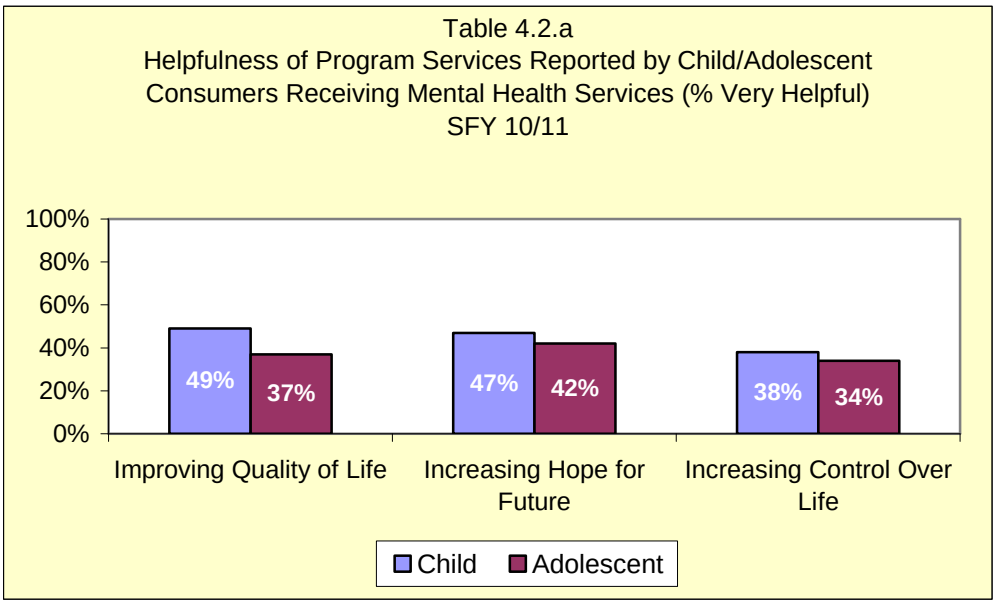


SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2009-10, North Carolina (NC) compared to All Participating States (All).

Measure 4.2: Outcomes for Persons with Mental Health Disorders

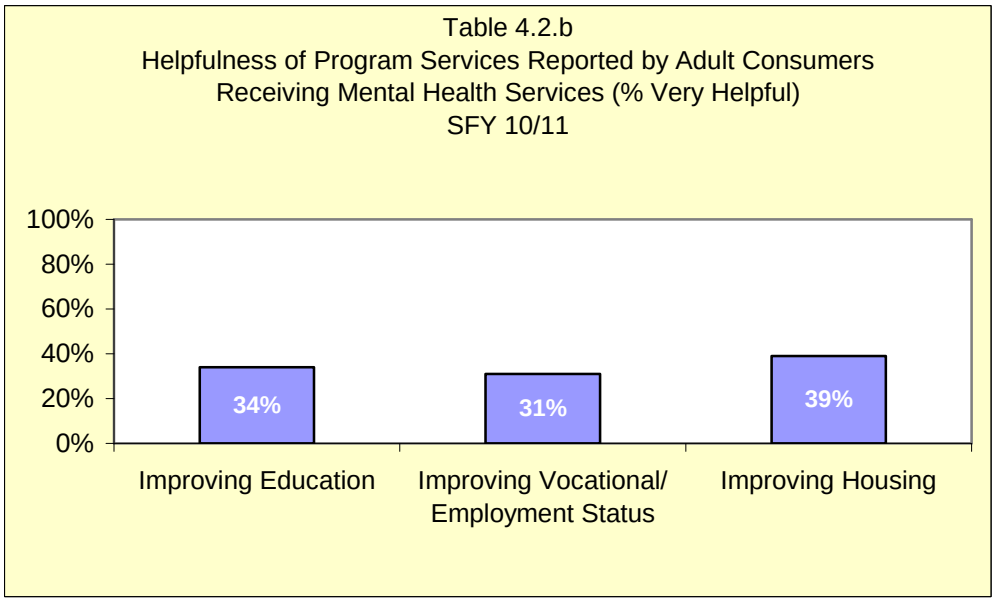
Table 4.2.a, on the next page, shows how adolescent mental health consumers and parents/guardians of child mental health consumers in SFY 2010-11 perceived the impact of the first three months of treatment in three important quality of life indicators. Just under half of parents/guardians reported their child's services were very helpful in improving their child's quality of life and hope for future, 49% and 47% respectively. Almost four in ten (38%) of parents/guardians also stated services were very helpful in increasing their child's control over his/her life. Adolescents, however, reported slightly lower rates for helpfulness of program services for all three quality of life indicators. Slightly less than four out of ten (37%)

adolescents reported services had improved their quality of life. Forty-two percent stated services were very helpful in increasing their hope about the future and approximately one-third (34%) of adolescents reported that services were very helpful in increasing control over their lives. (See Appendix B for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3-Month Update Interviews conducted July 1, 2010 - June 30, 2011.

For adults with mental illness, housing and employment are important to regaining personal control of one's life. Table 4.2.b below, shows how adult mental health consumers in SFY 2010-11 rated the impact of the first three months of treatment in three key areas of their lives. (See Appendix B for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2010 - June 30, 2011.

- Approximately one-third of adults (34%) reported that services helped improve their education.

- Almost one-third of adults (31%) reported improvements in their vocational/employment status.

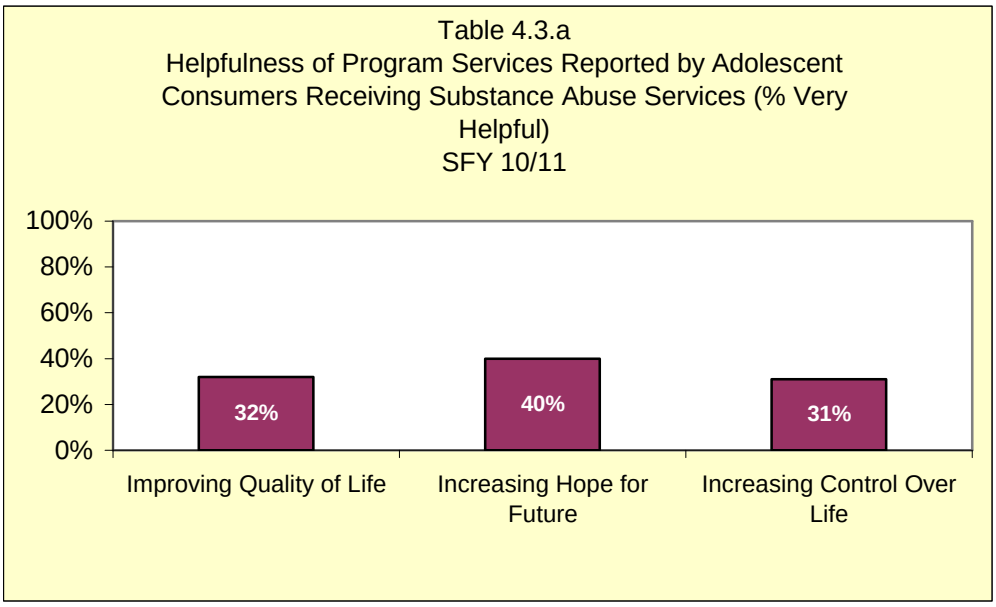
- Almost four out of ten (39%) adults reported that services helped improve their housing situation.

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

National measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a short time, as shown in the data from NC-TOPPS consumer interviews. (See Appendix B for details on the NC-TOPPS system used to collect this data.)

As seen in Table 4.3.a below, 32% of adolescent substance abuse consumers in SFY 2010-11 stated that program services were very helpful in improving their quality of life, four in ten (40%) reported services were helpful in increasing their hope about the future, and 31% reported services were helpful in increasing control over their own life.

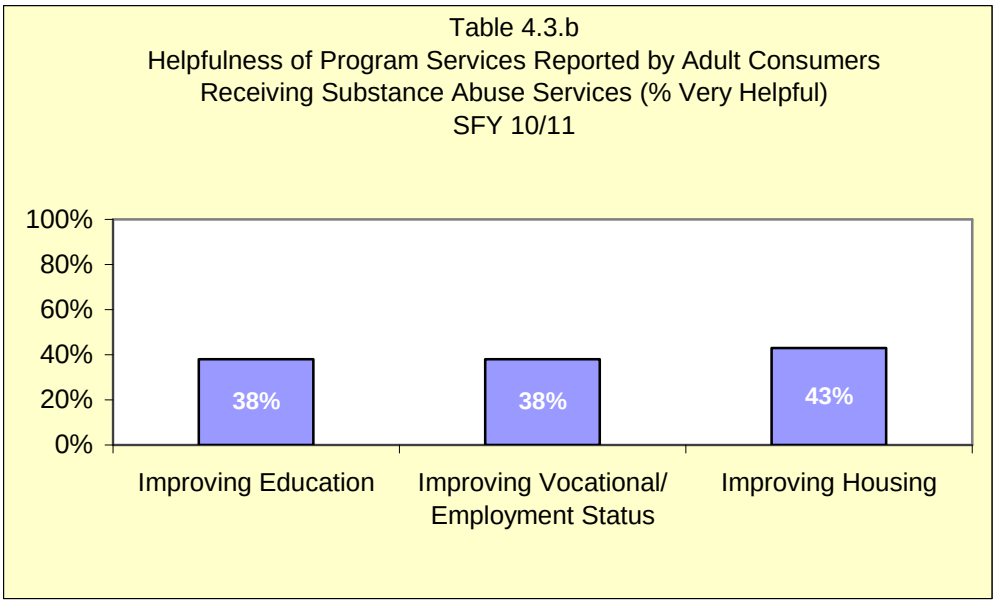
Table 4.3.a
Helpfulness of Program Services Reported by Adolescent Consumers Receiving Substance Abuse Services (% Very Helpful)
SFY 10/11



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2010 - June 30, 2011.

Table 4.3.b, on the next page, shows how adult substance abuse consumers in SFY 2010-11 perceived the impact of the first three months of treatment in three essential areas of their lives. Again, perceptions after three months of service is primarily an indicator of the individual's hope for recovery and engagement in services, both of which are key for achieving and sustaining

improvements over time. (See Appendix B for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2010 - June 30, 2011.

- Approximately four out of ten (38%) adult SA consumers reported that services were vey helpful in improving their education.

- Thirty-eight percent of adult SA consumers reported services were very helpful in improving their vocational/employment status.

- Forty-three percent of adult SA consumers reported program services as very helpful in improving their housing situation.

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.

- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.

- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.

- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled quality assurance, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled quality improvement, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Partnering for Success and the 1915 b/c Medicaid Waiver

The Department is in the process of expanding the 1915 (b)/(c) Medicaid Waiver which is scheduled to be fully implemented in January 2013. As a part of this expansion process, the Department has established several committees to provide guidance, technical assistance, and monitoring for the Local Management Entities (LMEs) as they become Managed Care Organizations (MCOs) (also known as LME-MCOs). One such committee is the Intra-Departmental Monitoring Team (IMT) which has been established to provide guidance, assist with questions and problems, and provide monitoring and oversight to each LME as they transition to an LME-MCO. Members of the IMT include staff from the Division of Medical Assistance, the Division of Mental Health/Developmental Disabilities, and Substance Abuse Services, the LME-MCO, and the Department. Each IMT meets monthly to review progress, any State concerns, LME-MCO challenges encountered, technical assistance needed, and implementation successes.

Two additional committees were formed to assist with the expansion process. The Aggregate IMT, comprised of representation from DHHS, meets monthly and discusses the strengths and concerns of all LMEs as they work to implement the Medicaid Waiver. Information from this committee is shared with the Executive Leadership Team at DHHS and specific IMT staff when appropriate. The DHHS Waiver Advisory Committee (DWAC) is made up of DHHS staff as well as representatives from various stakeholder groups; for example, local and state CFAC members, state provider associations, local provider representatives, and county commissioner association representatives. This committee is charged with providing stakeholder input into the Waiver implementation and operations process. It meets monthly during the first year of the Waiver implementation and provides input and consultation to LME-MCOs. After implementation, the DWAC will meet quarterly to review performance measures and trend data for LME-MCOs to monitor their progress and performance as Waiver entity.

Measure 5.2: Consumer Health and Safety Committee

In an effort to monitor and ensure timely responses to consumer adverse events, the Division has established the Consumer Health and Safety Committee. This committee is chaired by the Customer Service and Community Rights Team Leader or designee, and its membership includes representatives from Division teams that are responsible for consumer grievances and appeals, provider accountability, and clinical quality of services. This committee meets monthly and its responsibilities include the following:

- conduct regular reviews of patterns and trends in complaints, appeals, consumer incidents, prescription monitoring, and NC health indicators and report summaries to the Quality Steering Committee,
- provide guidance to LMEs on response to individual complaints and incidents, as needed,
- identify emerging issues and make recommendations for action to the QM Steering Committee, and
- implement approved action plans and report progress and results to the Quality Steering Committee.

To fulfill these responsibilities, linkages are made with other agencies, such as the Division of State-Operated Healthcare Facilities, the Division of Health Service Regulation, and the Division of Medical Assistance. Further, the committee reviews data and reports from the Division's web based incident reporting system, Incident Response Improvement System (highlighted in the *Semi-Annual Report to the Joint Legislative Oversight Committee on Health and Human Services on Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report SFY 2009-10: Fall Report*) as well as quarterly complaint reports from the LMEs. These data provide information on individual incidents and complaints as well as statewide trends for monitoring purposes.

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and thorough information management.

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

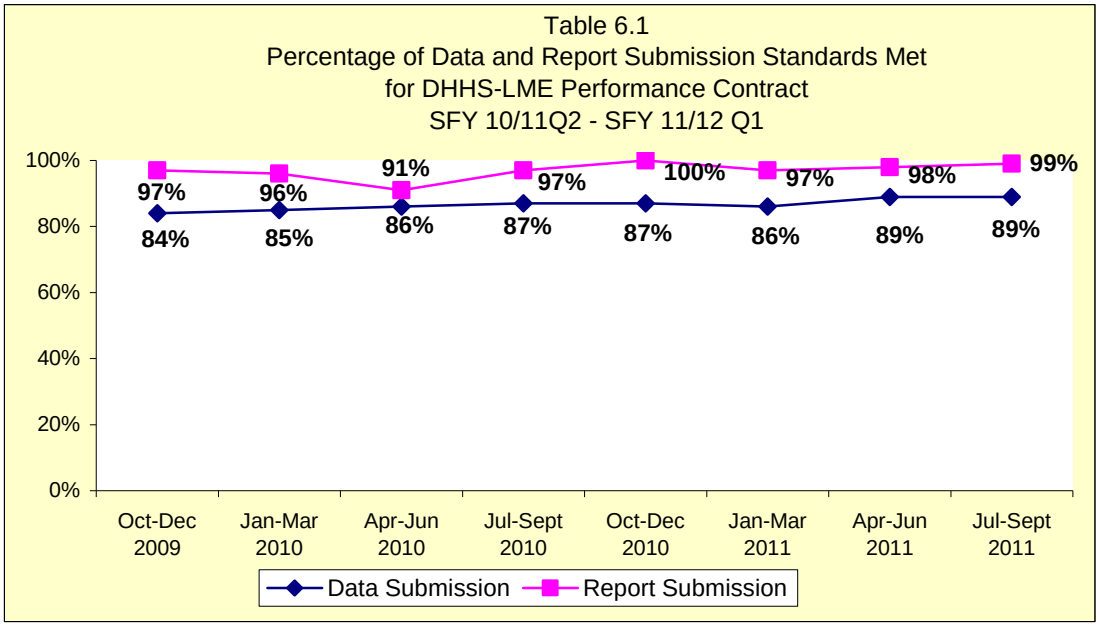
The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. It includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform, reporting expectations, and critical system performance indicators.

Measure 6.1: Business and Information Management

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead. For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely and accurate submission of financial and consumer information. Taken together, the LMEs' compliance with reporting requirements

provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

Table 6.1 shows the LMEs' submission of timely and accurate information over the past eight quarters. Data submission has risen five percentage points from 84% to a high of 89% while the submission of reports has fluctuated between 91% and 100% during the same time period. For all eight quarters, the percentage of report submission standards met was consistently higher than data submission.



SOURCE: Data from Quarterly Performance Contract reports, SFY 09/10 Q2 though SFY 11/12 Q1.

Measure 6.2: Performance on System Indicators

The Division continues to monitor the effectiveness of community systems through statewide performance indicators. The regular reporting of community progress assists local and state managers in identifying areas of success and areas in need of attention, as well as holds every part of the system accountable for progress toward the goals of mental health reform. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities. The *DHHS-LME Performance Contract* assigns a standard for expected performance for each critical performance measure. Table 6.2, on the next page, displays the number of LMEs that met the performance standard for the measures as referenced in the *SFY 2011 DHHS-LME Performance Contract*. The Division is working with the LMEs on areas where improvement is needed. In addition, the Division is currently reviewing performance measures for the SFY 2012 Performance Contract to determine areas where the service system has been successful, areas that need improvement, and new areas to focus efforts on in the future.

Table 6.2
Number of LMEs that Met the Performance Standard on Critical Performance Measures
(N=23 LMEs)
SFY 2011-12, 1st Quarter

Critical Performance Measure	Sub-Measure	Number of LMEs That Met the Performance Standard
Timely Access to Care	Urgent	18
	Routine	17
Services to Persons in Need	Adult MH	20
	Child MH	20
	Adult DD	20
	Child DD	14
	Adult SA	21
	Adolescent SA	22
Timely Initiation/ Engagement in Services	MH: 2 Visits in 14 Days	21
	MH: 4 Visits in 45 Days	17
	SA: 2 Visits in 14 Days	19
	SA: 4 Visits in 45 Days	19
Effective Use of State Psychiatric Hospitals	1-7 Days of Care	22
State Psychiatric Hospital Readmissions	30-Day Readmissions	17
	180-Day Readmissions	18
Timely Follow-Up After Inpatient Care	ADATCs: Seen in 1-7 Days	18
	State Psychiatric Hospitals: Seen in 1-7 Days	19

Domain 7: Prevention and Early Intervention

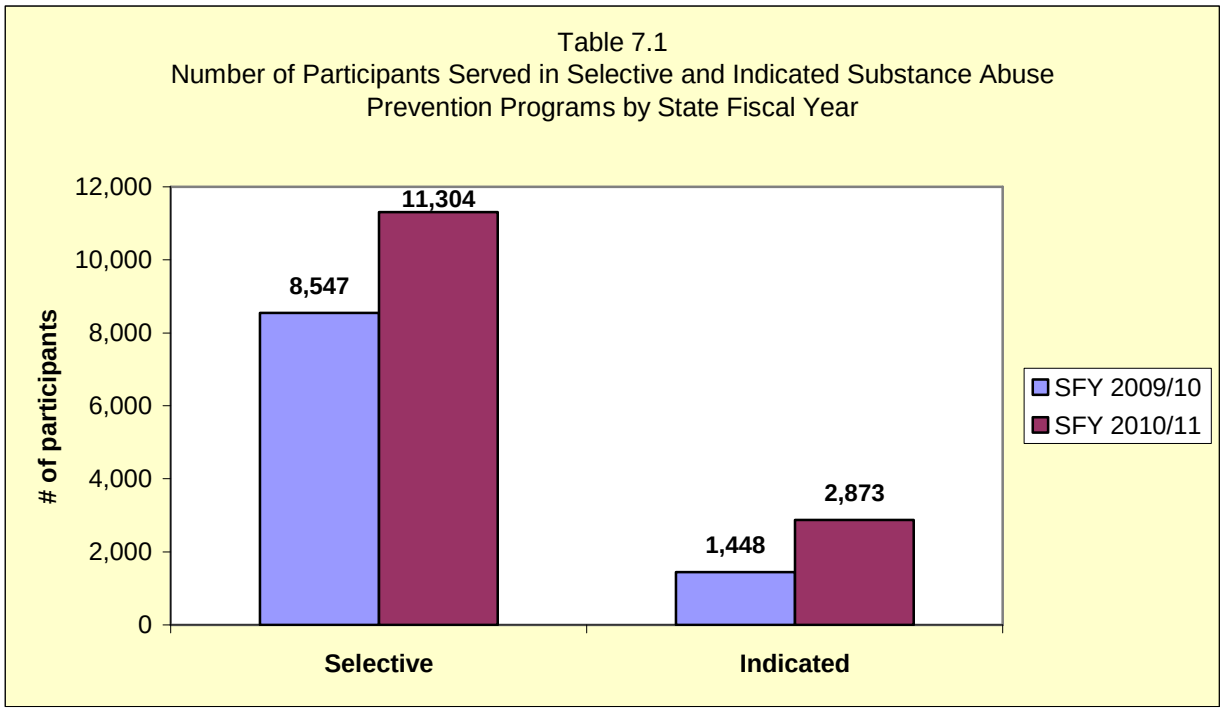
Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public and specific groups known to be at risk. Prevention education focuses on the nature of MH/DD/SA problems and how to prevent, recognize and address them appropriately. **Early intervention** activities target individuals who are experiencing early signs of an emerging condition to halt its progression or significantly reduce the severity and duration of its impact.

Measure 7.1: Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) set-aside funds (20% of the total funding) make up the largest portion of funding that target substance abuse prevention services in the Division. The SAPTBG provides funds for relevant programs, practices and policies identified through the "strategic prevention framework" process in local communities. In North Carolina, the SAPTBG prevention set-aside funds are used to support strategies (programs, practices and policies) implemented across the 100 counties and allocated to community providers based on a plan consistent with local needs. The Office of Prevention endorses the risk and protective factor model through implementation of evidence-based/informed strategies to universal, selective and indicated populations. A system of regionalized prevention centers supported by these funds helps with addressing local technical assistance needs.

In SFY 2009/10, evidence-based curricula programs and strategies reached 8,547 youth in the Selective target population and 1,448 in the Indicated target population. In SFY 2010/11, evidence based programs and strategies reached 11,304 youth in the Selective population and 2,873 in the Indicated population. The evidence-based curricula have been rigorously evaluated and replicated with the target populations to achieve outcomes such as: academic competence and achievement (performance and behaviors), behavioral self-regulation and social competence.

The increase in participants in the selective and indicated populations for the SFY 2010/11 is directly related to the use of appropriate and improved substance abuse prevention screening tools, problem identification and referral to the best service available. The increases in numbers served indicate the need to make available additional best practices for the selective and indicated populations (see Table 7.1 on the next page).



Source: Data from the North Carolina Prevention Outcomes Performance System (NC POPS), SFY 2009/10 and SFY 2010/11.

Measure 7.2: Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE)

The State's current substance abuse prevention infrastructure is being strengthened by a one year capacity building grant from the Substance Abuse Mental Health Services Administration (SAMHSA). The grant is allowing the state to utilize its epidemiological work group to identify social indicators across 100 counties of North Carolina that impact substance use/abuse. A Policy Consortium has been developed consisting of public and private stakeholders to garner support for identifying substance abuse problems in local communities and developing a plan with recommendations to address them. The grant project director has submitted a preliminary capacity plan to (SAMHSA) for approval that includes a cultural responsiveness plan to be used to train prevention professionals.

Appendix A: Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, Session Law 2011-291, Section 2.42 (c) revised NC G.S. 122C-102(c) to read:

> "The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Health and Human Services, on the State's progress in these performance areas."

Appendix B: Description of Data Sources

Domain 1: Access to Services

Table 1.1.a Persons in Need (*Prevalence Rates*): The estimates of the percentage of individuals who experience a mental health, developmental, and/or substance abuse disability each year come from the following sources:

MH Prevalence Rates: Prepared by NRI/SDICC for CMHS, July 6, 2010 (for the MH Block Grant)

- Children: URS Table 1: Children with Serious Emotional Disturbance, ages 9-17, by State, 2009. Note: 11% is the midpoint (10%-12%) for the LOF=60 range (SED with substantial functional impairment). The same rate was applied to children under age 9.

- Adults: URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2009 = 5.4%.

NC Substance Abuse Prevalence Rates: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2008 and 2009, published June 2011.

- Children and Adults: Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2008 and 2009 NSDUH.

- Prevalence rate for adolescents (ages 12-17) is 6.00%, for adults (ages 18-25) is 17.36%, and for adults (ages 26+) is 6.32%. Total = 7.68%. Applying these age group rates to July 2011 population = 7.82% total.

DD Prevalence Rates: Larson, S., Lakin, C., Anderson, L., Kwak, N., Lee, J.H., & Anderson, D. (2000). Prevalence of MR and/or DD: Analysis of the 1994/1995 NHIS-D. MR/DD Data Brief, April 2000, Vol 2, No. 1. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. The NHIS-D is the National Health Interview Survey (NHIS) Disability Supplement used to estimate the prevalence of people with MR and/or DD in the US Non-Institutional Population. According to the article, prevalence rates for persons ages 3-5 = 3.84%, ages 6-17 = 3.17%, and ages 18+ = 0.79%. Based on July 2011 NC projected population, and excluding children ages 0-2 who receive services from DPH, 1.30% of the total NC non-institutionalized population and 1.32% of the total population (including persons in institutions) are estimated to have MR and/or DD. If persons ages 0-2 were to be included, the prevalence rate for the non-institutionalized population would be 1.40% and the prevalence rate for the total population would be 1.42%.

Table 1.1.a and Table 1.1.b Percent of Persons in Need and Served (*Treated Prevalence*): The percent of persons in need who receive services is calculated by dividing the number of persons who received at least one Medicaid or state-funded service (based on paid claims in the Integrated Payment Reimbursement System (IPRS) and/or Medicaid claims system for the time period July 1, 2010 through July 30, 2011) by the number of persons in need of services. The number of persons in need (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA). The disability of the consumer is based on the diagnosis reported on the service claim. Persons with multiple disabilities are included in all relevant groups. Currently, this information is being published in the quarterly *Community Systems*

Progress Report. More information on this report can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Table 1.2.a Percentage of Persons Receiving Timely Access to Care: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the required time period (14 calendar days) and multiplying the result by 100. The information comes from data submitted by LMEs to the Division. The Division verifies the accuracy of the information through annual on-site sampling of records. Currently, this information is being published in the quarterly *Community Systems Progress Report*. More information on this report can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Table 1.2.b Service Met in Time Frame that Met Needs of Consumers: The data presented in these tables come from clinician-to-consumer initial interviews that occurred between July 1, 2009 and June 30, 2010 through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule from all persons ages 6 and over who receive enhanced mental health services and 12 and over who receive substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm. Within age groups, mental health and substance abuse consumers overlap due to co-occurring disabilities.

Domain 2: Individualized Planning and Supports

Tables 2.1.a Choice Among Persons With Mental Health And Substance Abuse Disabilities: This information comes from NC-TOPPS, described in Table 1.2.b above.

Tables 2.1.b Control Over Daily Decisions for Persons With Developmental Disabilities: The data presented in these tables are from in-person interviews with North Carolina consumers in project year 2009-10, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.2.a Family Involvement for Consumers With Mental Health And Substance Abuse Disabilities: This information comes from 3-Month update interviews conducted in SFY 2010-11 in NC-TOPPS, described in Table 1.2.b above.

Tables 2.2.b Input into Planning Services and Supports for Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.b above.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Providers of Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Table 3.2.a Short Term Care in State Psychiatric Hospitals: The data come from the Division's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) HEARTS discharges for the period July 1 - September 30, 2011. The HEARTS data include demographic, diagnostic, length of stay and treatment information on all consumers who are served in State-operated facilities. Lengths of stay are calculated by subtracting the date of admission from the date of discharge. The percents for each length of stay grouping (1-7 days, 8-30 days, 30-365 days, and over 365 days) are calculated by dividing the total

number of discharges during July 1-September 30, 2011 into the number of discharges in each length of stay grouping and multiplying by 100.

Table 3.2.b Admissions to ADATC Facilities: These data come from the Division's HEARTS data for SFY 2007 through SFY 2011 as reported in the Consumer Data Warehouse (CDW).

Table 3.3.a Follow-up Care for Consumers with Developmental Disabilities Discharged from the General Population of the State Development Centers: These data come from reports submitted quarterly by the developmental centers to the NC Division of State Operated Healthcare Facilities. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Table 3.3.b Follow-up Care for Consumers with Developmental Disabilities Discharged from the General Population of the State Development Centers: The data come from HEARTS direct discharges during the period April 1 – June 30, 2011 and Medicaid and State Service Claims data for April 1- October 31, 2011. Discharges to other state-operated facilities and the criminal justice system are not included. The time between discharge and follow-up care is calculated by subtracting the date of discharge from the date of the first claim for community-based service that occurs after the discharge date. The percents of persons seen within 7 days, 8-30 days, 30-60 days, and greater than 60 days are calculated by dividing the total number discharged during the period into the number in each of the groupings of time to follow-up care.

Domain 4: Consumer Outcomes

Tables 4.1 Service Outcomes For Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.b above.

Tables 4.2 and 4.3 Service Outcomes for Individuals With Mental Health And Substance Abuse Disabilities: This information comes from the 3 month update interviews conducted in SFY 2010-11 in NC-TOPPS, described in Table 1.2.b above.

Domain 6: Efficiency and Effectiveness

Table 6.1 Business and Information Management: The data for information management come from calculations of compliance for requirements in the *DHHS-LME Performance Contract*.

Table 6.2 Efficient Management of Service Funds: This data on Utilization Review activities come from Value Options as well as Durham and Eastpointe LMEs.

Domain 7: Prevention and Early Intervention

Table 7.1 The Number of Participants Served in Substance Abuse Prevention Programs, Policies, and Practices: This information comes from the North Carolina Prevention Outcomes Performance System (NC POPS). More information on this system can be found at http://kitusers.kithost.net/support/nc/Home/tabid/868/Default.aspx

7.2 Strategic Prevention Framework-State Prevention Enhancement (SPF-SPE). Information on the SPF-SPE can be found at www.preventionistheanswer.org